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Translation and Healthcare in Europe:

An Overview of Europe's Legal Framework

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Abstract

When healthcare professionals and patients are unable to communicate in the same language, a barrier arises. This barrier can be torn down through translation and interpreting. As obvious as that may sound, there is little research into translation policies in healthcare. This paper aims to help fill in that gap by exploring, from a descriptive standpoint, the existence of European legal standards regarding how to bridge the language barrier when patients attempt to access healthcare. Specifically, it will consider legal instruments from the European Union and the Council of Europe regarding access to healthcare whenever there are language differences among persons. In doing so, it will show that translation is not always front and centre when it comes to pan-European legislative pressures that address issues of language in healthcare.

Keywords

healthcare, translation, law, European Union, Council of Europe

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1. Introduction

Europe today is a place where, thanks to the increased mobility provided in part by the free movement of persons, the multilingual[1] reality of the continent becomes increasingly apparent. This multilingual reality can rightly be viewed as an asset. Even so, dealing with multilingualism can present a number of challenges in different settings, including healthcare settings. For example, when healthcare professionals and patients are unable to speak in the same language well enough, a communication barrier arises. This barrier may have more adverse effects in initial access to healthcare than any other factor (Committee of Experts on Health Services in a Multicultural Society 2006: 13). Further, a failure to communicate properly once in a healthcare situation can have adverse effects such as mistreatment, misdiagnosis, misprescription of doses, non-performance of follow-up care and even death (Spolsky 2009: 45-46, 126; see also Hampers et al. 1999; Flores et al. 2003; Goldman et al. 2006). Other adverse effects of language barriers in healthcare include lack of patient satisfaction, lack of provider satisfaction, failure to meet standards of care and increased risk of professional liability (Committee of Experts on Health Services in a Multicultural Society 2006: 13; for a survey of academic literature of the effects of language barriers in healthcare provision, see Pöchhacker 2006: 140, 149-150).

In this paper we assume that, because of the stakes at play, the challenges that result from multilingualism in healthcare settings should be dealt with. Further, we understand that one possible way of dealing with these challenges is through translation,[2] particularly translation carried out by professional translators/interpreters. Translation can be a useful tool in helping to bridge the language barrier and thus in addressing some of the challenges posed by multilingualism in healthcare settings. Aware of translation's potential as a tool to help overcome language barriers in healthcare, in this paper we explore the question of whether there are European legal

1. By "multilingual" we mean a space where several languages coexist. Thus, multilingualism in a healthcare setting can be seen when a space where healthcare is provided is found to have speakers of several languages.

2. In this paper, the term "translation" will be understood broadly as the process or product through which a message is transferred from one language to another. This definition is an umbrella term that covers written and oral forms of translation, but whenever a distinction must be made between both forms, the terms "written translation" and "interpreting" will be used to signal that distinction.

standards to assure that individuals who do not speak the majority language can bridge the language barrier when attempting to access healthcare.[3]

We stress that this paper addresses issues pertaining to healthcare. Such a focus should not be understood to mean that translation is not important in other areas affected by language policy. For example, there is an explicit role for translation in criminal justice (see, e.g., Hertog and Van Gucht 2008; Baigorri and Campbell 2009; Brannan 2010). For the purposes of this paper, however, the focus is placed, through a descriptive paradigm, on legal pressures to use translation as a tool for dealing with the issues described in this section.

2. Method and rationale

The search for European legal standards regarding access to healthcare in multilingual states can start at two very different places. One starting point is the ground level. An example of this bottom-up approach is research through fieldwork (e.g., video recordings), questionnaires, interviews, simulations and role-plays (see Pöchhacker 2006: 154-155). Such a bottom-up approach would reach out to hospitals and similar venues throughout Europe with surveys and interviewers to get an understanding of the regimes in place. The other starting point is at the top. A top-down approach could consider legislative pressures placed on healthcare providers across the continent. Such an approach would consist of gathering legal instruments that apply across Europe and analysing them accordingly. Because of the European Union's (EU) and the Council of Europe's (CoE) impact on many states across Europe, it would make sense to begin such a top-down approach by considering the specific mandates these organisations place on national healthcare systems when dealing with multilingualism, so as to evaluate their implications for translation.

This study recognises that many bottom-up approaches have been successfully undertaken in exploring the issue of translation and healthcare (e.g., Pöchhacker and Kadric 1999; Flores et al. 2003; Martin 2006; Ginsburg 2007; De Pedro Ricoy et al. 2009). One way the study hopes to make a contribution is by taking the opposite approach and starting at the top. This way it hopes to add a different viewpoint to exist-

3. For an exploration of more general state obligations to translate under international law, see González Núñez 2013b.

ing scholarship on the topic. First, it will consider the EU and then the CoE in terms of the extent to which each organisation has and can be involved in the intersection of language and healthcare, and from that it will draw conclusions regarding the mandated use of translation.

When it comes to EU healthcare regulation, translation is not an object of explicit concern. However, there are a number of legal instruments that have implications on language policy, and consequently on translation policy (see Meylaerts 2011: 744-745). Most of the relevant provisions dealing with language fall under two types. The first type, which we shall call institutional language requirements, is concerned with solving the challenges that arise when institutions that use different languages have to communicate with each other. The second type, which we shall call public language requirements, is concerned with solving the challenges that arise when the public is concerned, whether that be the general public or a specialised public. It is on this second type of language requirements that we will focus in this study. When dealing with these public language requirements, we will consider legal instruments that affect EU fundamental freedoms, as this is where the issues of language and healthcare tend to meet. In the relevant fundamental freedoms, we will identify specific legal instruments that are pertinent to this study's research question (see Appendix I for a complete listing of instruments consulted for this study) of whether there are European legal standards to assure that individuals who do not speak the majority language can bridge the language barrier when attempting to access healthcare. These instruments, and any relevant judicial interpretations, will in a further step be analysed for language and translation implications. A similar approach will then be taken to survey of CoE treaties that may impact the issue at hand, as well as some CoE recommendations that are very much on point.

3. Language and healthcare in the European Union

3.1. Subsidiarity in language and healthcare

As the EU has expanded, the issue of language has become more pressing for policy makers.[4] The EU has dealt with the ever-growing number of languages spoken by the

4. For an exploration of the EU's linguistic diversity, see Arzoz 2008.

roughly five-hundred million European citizens through favouring multilingualism. This has two obvious manifestations, one mostly political and the other mostly practical. The political manifestation is that institutionally the EU has 24 official languages. Every member state can designate one of its official languages as an official language of the EU. These languages are intended to have equal status (Gubbins 2002: 47), which in theory gives equal linguistic status to every member state in the EU. Thus, this "symbolic affirmation" revolves around the political recognition of member *states* (Arzoz 2008: 6). The practical manifestation is that the EU encourages citizens of Europe to learn two EU languages on top of their mother tongue ("mother tongue plus two") and provides funding for programmes that promote learning additional languages (Extra and Gorter 2008: 38, 44). A look at these two approaches to Europe's multilingual reality leads to the conclusion that the EU does not provide a common language policy for European states (ibid.: 38). Language policy, with its attendant translation policy, is handled by individual member states (ibid.: 38, 42).

This makes sense in light of the principle of subsidiarity, according to which the EU can only act in areas where it has exclusive competence or where action by one member state alone is insufficient (Folsom 2011: 53). When it comes to a member state's language policy, there is no perceived need for coordination with the rest of the EU. Decisions on language policy are public responsibilities, and, "[a]ccording to the principle of subsidiarity, public responsibilities are best exercised by the authorities that are closer to the citizen" (Arraiza 2011: 126). The subsidiarity principle additionally plays a role in healthcare. In this regard, the EU does have some competence to regulate healthcare, but it is very limited. The *Treaty on the Functioning of the European Union* indicates that the EU can "support, coordinate or supplement the actions of the Member States" in the "protection and improvement of human health" (Art. 6), and it can "complement national policies" to ensure a high level of protection of human health (Art. 168(1)). Thus, healthcare remains, for the most part, a national competency.[5] What the EU can do, and has done, is implement directives and regulations as well as fund programmes to promote public health

5. Because of this, the search for pan-European legal standards can only be a first step in an avenue of research that could continue by exploring the legal framework that provides for the use of translation at the state level. This paper only claims to be a first step, a starting point from which to launch further research.

(Hervey and Vanhercke 2010: 88).

Language and healthcare are not discrete policy areas. They are inexorably linked, as are other policy areas. It is crucial that healthcare providers, including doctors and nurses, be able to communicate with patients. However, solving the problems that arise when care providers and patients do not speak the same language can seem an expensive, complicated and difficult undertaking. Perhaps this is why the different options used by healthcare providers, when confronted with language difficulties (such as bilingual staff, professional interpreters, contracted translators for texts, volunteers, language assistance hotlines), are often the result of pressure from the outside, including regulation and the threat of lawsuits (Spolsky 2009: 127-128). For example, in the United Kingdom (UK), non-discrimination legislation, including the Equality Act 2010, legally binds healthcare providers to give equal access to healthcare services to those with limited English proficiency. Faced with the legal requirement to grant access to their services to those who do not speak sufficient English, healthcare providers turn to different forms of translation, including the translation of leaflets and the hiring of face-to-face interpreters (see, e.g., González Núñez 2013a: 9-10).

3.2. The free movement of persons/services in the EU

Public language requirements arise in a healthcare context as the EU attempts to regulate the internal market in order to guarantee certain fundamental community freedoms, including the free movement of persons/services. Free movement of persons refers to the freedom of EU citizens to move between member states for different purposes, and free movement of services refers to the freedom of individuals or companies to offer services across EU borders, either temporarily or (under freedom of establishment) more permanently.[6] This paper approaches the matter with a concern for individuals, not companies, and will thus consider only the free movement of services in terms of people offering their services in another member state. Language issues arise in relation to these freedoms of movement (persons/services), and our focus will be on healthcare professionals and patients. Individuals who move to another member state can generally expect under EU law to be subjected to the same language requirements as the rest of the member state's

6. In this paper, the term "freedom of services" is intended to cover the freedom to provide services temporarily and permanently, even when permanent services involve the freedom of establishment.

population, as long as these requirements are proportional to the member state's policy aims and non-discriminatory in their application (Nic Shuibhne 2001: 63-64). This means that member states get to introduce their own language rights regimes, but "there must be non-discriminatory implementation where such rights have already been provided for internally" (ibid.: 64). Individuals, particularly if they relocate more or less permanently, will require healthcare services sooner or later. In receiving those services, they can expect to be legally subjected to the same language requirements that apply to everyone else seeking treatment, as long as these requirements are not discriminatory. However, particular language issues arise in the context of healthcare, especially when dealing with the free movement of professionals and the free movement of patients. In dealing with these issues, translation is not as central as in dealing with moving products.

3.2.1. Professionals

EU regulation is designed to facilitate the movement of professionals who wish to establish their practice or provide their services in a different member state. In such cases, the same principle mentioned in the first paragraph of section 3.2 applies: member states may impose requirements for linguistic competence in order for professionals to practice their trade, but such requirements must be proportional and non-discriminatory (Nic Shuibhne 2001: 64). In the field of healthcare, this principle for a long time has been manifested in *Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications*.

The directive seeks to further the free movement of professionals by providing mechanisms for recognition of professional qualifications earned in a different member state. The aim is to afford individuals the freedom to pursue certain professions in a different member state. Under the directive, a number of medical professions – including "doctors, nurses responsible for general care, dental practitioners, [...] midwives [and] pharmacists" (recital 19) – enjoy automatic recognition in all EU member states. However, medical professionals who benefit from recognition under the directive must "have a knowledge of languages necessary for practicing the profession in the host Member State" (Art. 53). This rule is meant as a hedge against sacrificing patient safety for the sake of professional mobility

(Directorate General Internal Market and Services 2011: 70). From a statutory point of view, the hedge is language acquisition, not translation.

The exact way this rule plays out under the directive is yet to be interpreted by the Court of Justice of the EU (CJEU). Even so, while ruling on other legislative acts, the CJEU has found that there are legitimate considerations for imposing language requirements for professionals from other member states. These include the need for the professional to communicate with patients and pertinent authorities,[7] and, in some limited circumstances, a public policy to promote a specific language.[8] Thus, the CJEU has made clear that it is willing to permit language requirements that limit the free movement of professionals.

The Court of Justice of the European Free Trade Association States has had the opportunity to flesh out the contours of the language rule. In its recent judgment in *Dr A*,[9] the court advised that a European Economic Area (EEA) state cannot impose conditions that would deny recognition of a doctor's qualifications from another member state if the qualifications meet the requirements found in the directive. However, an EEA state can subject persons pursuing the practice of a profession inside their territory to national authorisation requirements to ensure consumer protection. Requiring language skills to practice as a doctor serves the public interest and is necessary under the directive. Even so, the linguistic skills requirement should apply only to linguistic skills necessary for practicing the profession, and the doctor should be given the opportunity to attain those skills if they need to be acquired. No mention is made of any possible role for translation (e.g., providing interpreters for those doctors) under the rule. Further, according to the principle of proportionality, EEA states cannot impose systematic language tests.

Not being able to require systematic language testing is a controversial result of the directive and its interpretation. The controversy has come to the forefront as the

7. See *Haim II*, where the court observed that "the reliability of a dental practitioner's communication with his patient and with administrative authorities and professional bodies constitutes an overriding reason of general interest such as to justify making the appointment as a dental practitioner under a social security scheme subject to language requirements" (para. 59).

8. See *Groener*, where imposing a language requirement for being hired to a full-time post is found to be permissible as long as the post is "of such a nature as to justify the requirement of linguistic knowledge" and two conditions are met: (1) "that the linguistic requirement in question is imposed as part of a policy for the promotion of the national language which is, at the same time, the first official language" and (2) "that that requirement is applied in a proportionate and non-discriminatory manner" (para. 24).

9. Appendix 2 gives full citations for every court case in this paper.

European Commission moves forward with its revision of the directive. Most member states favour amending the directive's language rule, as do a majority of professional organisations, competent authorities and trade unions (Commission Services 2011: 14). In the UK, for example, the revision of the directive has become a matter of public debate, with special attention to the inability to impose systematic language testing (see, e.g., Naish 2012). Currently in the UK, language competence is determined by the employer as needed, not by a systematic measuring of language skills (House of Lords 2011: 25). The House of Lords called for the updated directive to permit systematic language testing at the point of entry coupled with continued freedom for employers to determine language competency (ibid.). Others seem to agree (see, e.g., Dickson 2011: 5; Goddard 2011: 9). In the discussion surrounding the Directive and its judicial interpretation, the issue regarding whether there is a role for translation in the recognition of professional qualifications to practice in another member state is altogether avoided.

The concern is that systematic language testing may become a way to keep health professionals from working in member states other than their own. There is an inherent tension between free movement of professionals (e.g., doctors and nurses) and the protection of consumers (e.g., patients). Inasmuch as these two options are seen as two ends of a spectrum and not an either/or choice, a satisfactory solution may be sought. An opportunity for such a balance is offered by the current *proposal for a Directive of the European Parliament and of the Council amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation on administrative cooperation through the Internal Market Information System*.[10]

The proposal aims, among other things, at clarifying what the appropriate safeguards for patients are. To this end, the proposed new directive would allow for language controls to be carried out "under the supervision of the competent authority", after recognition but before accessing the profession, and only when "there is a serious and concrete doubt about the professional's sufficient language knowledge in respect of the professional activities this person intends to pursue" (para. 30(38)). This would apply to professionals generally. However, when it comes to professionals whose jobs have "public health or patient safety implications", the proposed new directive would take a more stringent approach. It would allow for

10. A political agreement has been reached regarding this proposal, and the directive will likely be adopted before December 2013.

systematic language checks. Even when these checks do take place, they can only check for knowledge of one official language (of the place where services will be provided), they must be proportionate to the tasks the professional is expected to carry out, and they must be free (para. 30(38)). Additionally, the professional could present evidence of knowledge of the language, and the language checks themselves would be appealable (para. 30(38)). This way, the proposal would allow member states to do more checking of language skills, particularly among health professionals, while at the same time establishing limitations and mechanisms to keep the checks from simply becoming an excuse to stop professionals from coming in across borders.

3.2.1. Patients

The EU has expended little energy on the issues that arise specifically when a patient gets care in a language that is not his or her own. This is not surprising, given the limited competences of the EU in healthcare (see section 3.1). Consequently, the approach to patients is the same as with any person moving into a member state where there is a different official language. No distinction is made between different types of patients who have moved. As stated in section 3.2.1, the focus is on official language acquisition instead of translation. In essence, the overwhelming majority of "institutional energies, and thus concrete action, have thus been concentrated on the relatively noncontroversial sphere of language learning" (Nic Shuibhne 2006: 378). The only rights in terms of language that patients can expect are that language rights generally extended to members of the state must be extended to those coming from another member state (Nic Shuibhne 2002: 23).[11] EU regulation focusing specifically on the free movement of patients has hovered around issues such as cross-border healthcare and coordination of social security systems. In the pertinent regulations, the issues that arise from patients not speaking the language of the healthcare system are peripheral at best.

Regarding cross-border healthcare, *Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare* is a key piece of legislation. The directive seeks to

11. For example, if a German electrician walks into a hospital in a German-speaking region of Italy, and that hospital treats patients in German, he can expect to be treated in German, but if he walks into a hospital in an Italian-speaking region of Italy, he can have no expectation to be treated in German.

establish rules that will make it easier for patients to access cross-border healthcare in the EU. Despite the relatively small number of cross-border patients, the directive "has important implications for managing health systems" (Jelfs and Baeten 2012: 24). A look at the directive reveals no right to language assistance, i.e., to translation, despite how crucial communication is between doctor and patient.

The directive does place some responsibilities upon the member states regarding information that is useful to patients, but it ignores any challenges presented by language barriers. The directive makes member states responsible for ensuring that (1) national contact points provide specific information regarding healthcare providers and that (2) healthcare providers provide specific information to patients from other member states (Art. 4(2)). This information is meant to protect patients by helping them make informed decisions. Along similar lines, patients are entitled to having access to their medical records (Art. 4(2)). However, the directive is to have no effect on the language laws of the member states (Art. 5). The information provided by national contact points should be "in any of the official languages of the Member State in which the contact points are situated," and it "may be provided in any other language" (recital 48). This effectively leaves the member states with the choice of whether to provide that information in any language other than one official language, meaning that some patients may be left with information from a national contact point or medical records that are not very helpful. Patients who do not speak the language of the state where they receive treatment are therefore left to their own devices when it comes to medical records and information (see Jelfs and Baeten 2012: 15-16, 23). In terms of promoting free movement of patients, the directive offers no solutions to the challenges presented by Europe's multilingualism. If more demanding EU requirements were to be adopted in this regard, they could potentially even have implications for the provision of medical services to non-cross-border patients who nonetheless speak a language that is not their state's official language. This may be one of the reasons the directive is keen to point out that it should have no effect on each member state's language laws.

4. Language and healthcare in the Council of Europe

Established through the *1949 Treaty of London*, the CoE is the oldest organisation dedicated to European union (Schwimmer 2010: 16). It seeks to foster unity among European states by creating and promoting common ideals (ibid.: 15, 17). According to the founding treaty, this is to be done by discussion and agreements "in economic, social, cultural, scientific, legal and administrative matters" and "the maintenance and further realisation of human rights and fundamental freedoms" (Art. 1(b)). Given its budgetary and structural constraints (Schwimmer 2010: 19), the CoE's most visible way of promoting common European ideals is through the drafting of conventions that are voluntarily adopted by CoE states. As of this writing, the CoE is responsible for over 140 conventions, "which form an extended network of legal standards for a variety of domains" (Wästfelt 2010: 31).

Yet a search among CoE conventions, whether dealing with "economic, social, cultural, scientific, legal [or] administrative matters" (Art. 1(b)), reveals no provisions that deal specifically with the challenges of multilingualism in healthcare. There are provisions that deal with healthcare, but not explicitly with multilingualism in healthcare. For example, the *Convention on Human Rights and Biomedicine* calls for signatories to "take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality" (Art. 3). This could be interpreted as meaning that states should look for ways to solve the challenges of multilingualism in healthcare, which in practice must include some level of translation, but it is far too vague to be the basis for a general European policy on this regard.

Similarly, the *Framework Convention for the Protection of National Minorities* (FCNM) calls for "the conditions which would make it possible to use the minority language in relations between those persons and the administrative authorities" (Art. 10). Article 10 of this convention is worth noting because it is under this article that the Advisory Committee that monitors compliance has tackled the issue of language in healthcare, expressing concern over weak translation measures in healthcare. Thus, Article 10 provides a possible foundation for a pan-European policy regarding multilingualism in healthcare. Specifically, it could serve as the basis for a transnational policy of allowing individuals who speak minority languages to access

healthcare in their own language. However, there are a number of limitations associated with Article 10 which must be taken into account.

The general obligation is vague in the sense that it does not impose specific obligations upon states, simply that certain conditions be created. (This, of course, has to do with the nature of a framework convention.) Further, the obligation is hedged in that all that governments have to do is create conditions which "would make it possible" for communication to take place. Additionally, the convention applies only to "national minorities" and not necessarily to any speaker of a language other than the language of the state. While no definition of the term "national minority" is provided by the drafters of the convention, there is a general understanding that this refers to groups that are autochthonous to specific areas of Europe (Medda-Windischer 2009: 45-46). The convention is intended to apply, for example, to groups such as Greeks, Macedonians and Montenegrins in Albania (Advisory Committee on the Framework Convention for the Protection of National Minorities 2003) or Russians, Belarusians, Ukrainians, Poles, Lithuanians and Estonians in Latvia (Advisory Committee on the Framework Convention for the Protection of National Minorities 2011). As these examples show, speakers of immigrant languages (including immigrant European languages) that are not autochthonous to the state in question would generally not be considered "national minorities" under the framework convention. In some contexts, however, they could be. Some states, like the UK, offer some of the framework convention's protections to all ethnic minority groups, regardless of origin. Thus, the UK has taken measures to offer free "interpretation and translation services in delivering health services" to individuals with limited English proficiency[12] (Advisory Committee 2007:16-17). This extension of some protection to speakers of immigrant languages under the framework convention represents the exception, not the rule (Medda-Windischer 2009: 47). For these reasons, it is hard to claim that this framework convention can

12. An example of how this plays out is provided by policy direction given by the Department of Health (DHS). DHS has asked NHS Trusts (local organisations that handle healthcare provision on the ground) to adopt translation policies for individuals who "genuinely need to communicate in languages other than English" (Department of Health 2005: 24). Among other specific instructions, DHS discourages relying on family members or friends to help fulfil those language needs (ibid.: 23). Thus, the general thrust of translation under DHS is that it should be provided, and by professionals, while specific questions regarding whether to use written translation or interpreting, what to translate, into which languages, in what settings and so on and so forth are left for local NHS Trusts to deal with.

act as the basis for a general European policy for dealing with the challenges of multilingualism in healthcare.

Besides conventions, the CoE has other types of instruments that could bear on national languages policies, but they are not binding. Such is the case of CoE recommendations and resolutions, which have no enforcement mechanism. Yet, it is in CoE recommendations that we find the issue tackled explicitly.

Recommendation Rec(2006)18 of the Committee of Ministers to member states on health services in a multicultural society addresses, among other things, the concern that patients' rights cannot be ensured if they are unable to communicate properly with healthcare providers. To that end, it suggests measures that focus on patients, interpreters and healthcare professionals.

Regarding patients, the recommendation suggests that states adopt a general language policy of teaching "the language of the host country" to those who do not speak it (Appendix (B)(3.1)),[13] thus helping to alleviate the language need from the patient's side. Regarding interpreters, the recommendation suggests that states hire professional interpreters to be regularly used by patients who may need them (Appendix (B)(3.2)). These professional interpreters should be properly trained to work in healthcare settings, which are characterised by particular structural, ethical, linguistic and cultural features (Appendix (B)(3.5)). Regarding healthcare providers, the recommendation suggests that they receive training on the effects of the language barrier and on how to work with professional interpreters (Appendix (B)(3.2)).

The CoE thus broadly suggests a two-fold approach to dealing with difficulties that may arise from multilingualism in healthcare: language acquisition and translation. As far as language acquisition goes, the CoE indicates that people who do not speak the language(s) of the state should obtain the language skills necessary to interact with the healthcare system. There is an important exception to this recommended approach, under Article 10 of the FCNM, "[i]n areas inhabited by persons belonging to national minorities traditionally or in substantial numbers, if those persons so request and where such a request corresponds to a real need". In such areas and under such circumstances, the authorities should make efforts to provide healthcare services in those languages. However, when it comes to those who do not speak the language(s) of the state, Recommendation Rec(2006)18 is that

13. These references are to Appendix B of Rec(2006)18, not any of the appendixes at the end of the present study.

efforts be made to teach the language of the state to such individuals. Doctors may also have some language learning to do if one follows to its logical conclusion *Recommendation Rec(2006)11 of the Committee of Ministers to member states on trans-border mobility of health professionals and its implications for the functioning of health care systems*. This recommendation deals with some of the challenges presented by professionals moving across borders. It suggests that "health professionals should be able to demonstrate a level of language proficiency consistent with safe and skilled communication with patients, clients, careers and colleagues" (Appendix 1(F)(6)). This recommendation, which addresses some of the same challenges as Directive 2005/36/EC, implies that professionals should be able to communicate in the language of the host state, but of course, in any given region, there may be a minority language that is spoken by a large portion of the population. In those cases, healthcare professionals would benefit from speaking that additional language.[14] As far as translation goes, Recommendation Rec(2006)18 suggests the hiring and training (not necessarily in that order) of interpreters. However, according to a study commissioned by the CoE, "untrained interpreters" are the norm in Europe,[15] even though the use of such interpreters can result in serious miscommunication due to their lack of interpreting skills and/or understanding of both cultures (Committee of Experts on Health Services in a Multicultural Society 2006: 15; see also Meyer et al 2010: 298). In practice, interpreters are often friends or family, which places them in very stressful situations and leads to the manipulation of the messages they are interpreting (ibid.; see also, e.g., Gill et al. 2011: 4). So hiring professional interpreters is a way to provide efficient translation in that they are

14. Teaching doctors to speak more than one language may be desirable in places like Brussels, where there is a dominant language (French) but also a language spoken by a lesser-yet-substantial number of speakers (Dutch). Both are official languages in the Brussels region. In 2002, several Dutch-speakers from Brussels lodged a petition with the CoE asking for the recognition of the language rights of Dutch-speakers in Brussels and the surrounding Flemish area when accessing healthcare. The petition arose from the fact that many Dutch speakers in the Brussels region cannot be attended by Dutch-speaking staff (due to such staff being much lower in numbers than the French-speaking staff). In the ensuing, non-binding *Resolution 1469 (2005), Language problems in access to public health care in the Brussels-Capital region in Belgium*, issued by the CoE, several recommendations were made. These included that a network of bilingual doctors be set up (Art. 7.7) and that "a language training programme in the medical schools of the region" be implemented (Art. 7.8).

15. This is the Committee of Experts' conclusion when looking at the member states of the CoE generally. The conclusion seems to be supported by studies in states like Slovenia, where immigration is a relatively new phenomenon (see, e.g., Pokorn et al. 2009), but it does not mean that every state in Europe is content to rely mostly on family, friends and bilingual staff for medical interpreting (see, e.g., the Advisory Committee's comments in the fourth paragraph of this section, including footnote 13, regarding the provision of interpreting in healthcare settings in the UK).

presumed to have sufficient interpreting skills, an understanding of both cultures in play and professional distance lacking in family or friends. The recommendation is silent regarding the written translation of documents. Thus, the use of translation it recommends is limited exclusively to verbal communications between patients and healthcare personnel. This is somewhat surprising. While the verbal communications are undoubtedly important, a great deal of communication between patients and healthcare providers takes place in written form, as is the case of medical files. The recommendation is, consequently, incomplete in this regard.

The responsibility of implementing this two-fold approach would fall upon the state. Perhaps not surprisingly, there is no evidence that states are lining up to follow these recommendations. This is understandable, as providing such solutions in a systematic way would be no small undertaking. Without the enforcement mechanisms of a convention, it is unlikely European states will feel too obligated to systematically adopt this language-acquisition-and-partial-translation solution to the challenges of multilingualism. *Ad hoc* measures, like those mandated by the EU, may continue to be the order of the day.

5. Conclusion

As we have attempted to show in this paper, despite its limited competences in healthcare, the EU exerts some influence on issues raised by multilingualism in healthcare through regulation of certain economic aspects. This influence can be seen in terms of the free movement of persons/services. When legislating for the free movement of professionals, the focus is on eliminating the language barriers to such movement. Mostly this is to be achieved through language acquisition, but even so, language competence is a thorny issue when it comes to professionals whose jobs have patient safety implications. Translation is present in the free movement of patients, as some translation is contemplated, particularly when it comes to social security coordination. This amounts to *ad hoc* rules that address none of the fundamental issues associated with language barriers in healthcare. What is missing here is a comprehensive approach to the crucial question of how to handle language differences in healthcare.

Whether the EU could do more in this regard is arguable. Certainly, because of

its limited healthcare competences, it cannot dictate translation policies for the provision of local healthcare. However, in areas such as cross-border healthcare, it could do more, such as directing that records of patients who come from other EU member states be translated into their own languages. But even something like that can become politically entangled. A proposal to engage in that type of translation is likely to encounter resistance on grounds that such translating is the responsibility of the home state or that those translations would take away resources from patients who live in the host state.

European states, however, have allowed other pan-European organisations to affect their domestic language policies. Consequently, our search for European standards that assure that individuals who do not speak the majority language can bridge the language barrier when attempting to access healthcare extended to the CoE, an institution that has tackled the issue more directly. It has recommended a two-fold approach that involves language acquisition by patients and doctors coupled with the use of professional interpreters (but not translators for written materials). This approach is not to be found in any binding instruments which deal with national minorities having access to healthcare in their own language. The creation of binding instruments to deal specifically with issues that arise when individuals do not speak the language of the state could be an important step in helping set a pan-European translation policy that would help remove language barriers to healthcare. At this moment, however, there are no legislative, pan-European standards for assuring that all individuals who do not speak the majority language well enough can bridge that language barrier when attempting to access healthcare.

If there are no European standards, the risk is that people who do not speak the language of the healthcare providers will be left to their own devices, with all the foreseen consequences, such as limited access to healthcare, limited access to pertinent information, lowered quality of care, higher risks of misdiagnosis and mistreatment, lower adherence to follow-up instructions, less effective management of chronic illness, less satisfaction on the part of patients and providers alike. A comprehensive approach to dealing with the language barrier is missing. This is an issue where more determined action by the EU and the CoE could be beneficial. Accordingly, a European convention on the provision of health services in multicultural societies that addresses issues of multilingualism, including translation, would be a most welcome development.

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Appendix I
Legal instruments consulted for the study

1. European Union

Treaty on the Functioning of the European Union

Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications

Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare

Proposal for a Directive of the European Parliament and of the Council amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation on administrative cooperation through the Internal Market Information System

2. Council of Europe

1949 Treaty of London

Framework Convention for the Protection of National Minorities

Convention on Human Rights and Biomedicine

Recommendation Rec(2006)18 of the Committee of Ministers to member states on health services in a multicultural society

Recommendation Rec(2006)11 of the Committee of Ministers to member states on trans-border mobility of health professionals and its implications for the functioning of health care systems

Resolution 1469 (2005), Language problems in access to public health care in the Brussels-Capital region in Belgium

3. National legislation

Equality Act 2010

Appendix II
Cases consulted for the study

1. Court of Justice of the European Free Trade Association States

Dr A, Case E-1/11, [2011] Rep. EFTA Ct. 483.

2. Court of Justice of the European Union

Haim v Kassenzahnärztliche Vereinigung Nordrhein, Case C-424/97, [2000] E.C.R. I-5148.

Groener v Minister for Education and the City of Dublin Vocational Education Committee, Case C-379/87, [1989] E.C.R. 3967.

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